6. *Plans and Programs:* This includes both governmental and private or voluntary health care plans or programs, or where applicable, combinations of these.

7. *Financing:* Financing includes both public and private financing, from voluntary and personal sources.

"CMA Quality Assessment Index for Health Care"

It is suggested that an effort be made to develop a "CMA Quality Assessment Index for Health Care" which would provide a description of the quality of health care and its various components and some sort of gradation of value just as in the "CMA Relative Value Studies" professional services are identified and a value placed upon them. It is suggested that such a quality index could be based upon the description of high quality health care to be found above through the application of the "parameters" to the "essential elements" of health care.

It is believed that when this concept is examined it will be found to encompass most of the existing approaches to the assessment or "measurement" of quality and to recognize the various viewpoints of those who are properly concerned with this problem. In application it could prove a valuable tool to identify areas of strengths and weakness in quality, and if kept up-to-date, it should provide a powerful ongoing incentive to up-grade quality.

Conclusion

1. The future of health care depends upon whether the concept of high quality can be maintained as a reality as the costs rise and the need to control costs increases, or whether "quality" will deteriorate to a meaningless slogan.

2. The practicing physician has a central role and responsibility in the core situation where the individual patient does or does not receive a high quality of medical care. The medical profession as a whole, and organized medicine in particular, therefore have a central role and responsibility for high quality health care.

3. It is clear that the responsibility for achieving the goal of high quality of health care for every person is widely shared and includes the patient, other members of the health care team, the health care industry, the voluntary and government health care plans, public and private sources of financing, together with educators, scholars in many academic disciplines, and many others, as well as the physician.

4. The Committee believes that there is now an unusual opportunity to develop a "CMA Quality Assessment Index for Health Care" as a tool to document quality and to encourage its betterment on a continuing and ongoing basis. It believes that such an index could be constructed which would assess the components of health care, utilize the "parameters of quality" described in this report, and, by means of statistically significant sampling maintain an ongoing record of the state and effectiveness of the control on "high quality health care" in California. Such a mechanism would be at once authoritative yet flexible and would encourage improvement in "high quality" rather than regulation and control at some fixed standard. The parameters, essential elements, and components could be adjusted periodically to reflect progress in science and society.

A Statement of CMA Goals

A Supplementary Report to the House of Delegates of the California Medical Association, 15 April 1967

At its 29 October 1966 meeting, the CMA Council voted "to prepare an annual broad statement of CMA objectives for presentation to the House of Delegates." The following statement of goals is an effort to comply with the Council's wishes regarding the annual establishment of goals for the Association.

WE HAVE RECOGNIZED that Medicine is an integral, interrelated and interdependent segment of the total population which it serves.

A state medical association exists as such because of the unique geographic, social, economic and political nature of the state itself. California is unique in its geography, its population size and varied composition, its industry, its economy, its educational facilities and its state government—especially its state government's involvement in, and regulation of the health professions and health care services.

The constitutional purposes of our medical association are the improvement of the art and the science of medicine and the betterment of the public health. It follows then, that the objectives of the California Medical Association in the years 1967-68 are: (1) **To improve the practice of**

medicine, and (2) **to aid in bettering the health of the public, accomplishing these tasks within the unique and changing social, economic and political environment of the State of California.**

Our major continuing goal, therefore, is to fulfill these objectives to the best of our abilities, utilizing as intelligently as possible all of the many diverse resources available to us.

In order to achieve this goal we must ask ourselves and others some searching questions to which we need complete and informative answers in order to formulate realistic programs and to guide our activities:

• *How can we effectively improve the art and science of medicine in California in the next few years?* Where are we now doing a "really good job?" Where are we "spinning our wheels" and wasting our resources? In what areas are we failing to do all that we can to help fulfill the needs and desires of our physicians to practice the art and science of medicine efficiently, productively and with the satisfactions which should be inherent in the practice of medicine?

• *What are the problems of public and community health toward the solution of which medicine could make more significant contributions?* In which of the large social problems affecting the health of the people are we providing effective medical guidance? In which of these problem areas are we failing for lack of direct involvement or for other causes? Are we identifying real community health problems and offering realistic proposals for their solution?

Evaluation of CMA Activities

Finding answers to just these few questions would require a thorough examination, not just of the profession itself, but of our relationships with other professions, paramedical personnel, medical schools, labor, industry, insurance carriers and with government at all levels. It would require realistic evaluation of the effectiveness of our relationships with county medical associations, the AMA, specialty societies, the Academy of General Practice and closed panel organizations. It would require critical evaluation of our communications techniques, our continuing education programs, group insurance, and retirement programs, to mention just a few.

Several of our committees and commissions and our Bureau of Research and Planning are scratching the surface of these problems, but in a manner often lacking coordination and clear recognition of purpose.

One of our immediate goals for 1967-68 might well be a complete critical evaluation of all CMA programs and liaison activities to determine whether or not they are realistically beneficial to either medicine or the public. The Council could conduct this evaluation using existing committees, with heavy reliance upon the Research Department.

Expansion of Governmental Relations Function

As such an evaluation progresses, it may become apparent that our manpower and other resources should be more heavily committed to some of our programs and withdrawn from others. For example, it is becoming increasingly apparent that there needs to be developed a strong, closely-coordinated government relations functions within the framework of CMA. This is made necessary by the vast involvement of government in the health care field and the complex, far-reaching implications of existing governmental programs and those planned for the future. Using larger numbers of well-informed physicians and an expanded staff, we must reach directly into the heart of those governmental advisory committees and administrative departments concerned with health matters. This we must do on a continuing basis, armed with current facts developed by meaningful research and supported by effective communications and by functional liaison with allied groups working in the same field.

This operation would not and should not replace nor duplicate the vital functions of the Public Health League, AMPAC, or CALPAC in their political and legislative activities. It would serve to support those functions and be coordinated with them, yet reach beyond their present spheres of influence into the vast maze of the administrative branch of government.

Modernization of Fact-Finding Methods To Utilize Resources Effectively

As one contemplates such a necessary redeployment of our available resources, it would seem wise for us to know just what these resources are. This would appear almost axiomatic, yet our state organization has never developed a systematic, effective way of maintaining, for example, an up-to-date listing of those physicians in various county societies who are particularly interested in, and working on, problems of school health, voluntary health

agencies, medical schools, or other specific areas. We have no ready index file of those influential leaders in industry or labor or education who could be called upon to assist medicine in a particular problem area. In this day and age, business and government achieve their objectives with the use of computer systems, rapid-fire changes of communications emphasis and of personnel deployment. Our medical organizations are lagging far behind.

An immediate goal for this Association should be the development of an inventory of our resources both within and outside of our immediate membership, utilizing modern, rapid methods of gathering this information and keeping it up-to-date and ready for immediate use. Your officers and executive staff should be charged with this responsibility. They will need to be supported by communications, research, and other segments of the Association.

Representation of All Segments of the Profession

It is perhaps more important now than ever before that CMA represent and speak for virtually all California physicians. We have yet to define clearly the mechanisms by which CMA can become a desired and valued place for participation by employed and salaried physicians in medical schools, closed panel groups, government services and training programs. **A "task force on membership" should be charged with study and recommendations on this subject.**

Enlargement of Physician Participation

Much of the work of an effective state medical association must be done by its physician members. Increasing demands on the profession have required untold hours, days and weeks of time from a handful of men and women at the helm of our organization, and to only a slightly lesser extent from various Councilors and members of committees, bureaus, task forces and commissions. There is still not nearly enough expenditure of time by well-informed physicians on all of the work the profession is or should be doing. The process of being well-informed on any given program or subject is itself tremendously demanding of time.

The pressures of practice, hospital committees, specialty societies, continuing education, community activities, family life and the need to make a living are such that only a few doctors have studied and worked in depth on the serious problems which confront the profession. **An immediate goal should be to increase significantly the number of physicians who will spend the necessary time to do this work, on a continuing basis on behalf of the Association and the profession.**

A major barrier to this goal is appropriate and reasonable compensation. We have long since passed the time when we could expect a physician to give up large segments of time away from his practice without some form of reasonable compensation. **This is a problem to be faced squarely. A realistic formula needs to be found promptly.**

Expansion of Member Services

The CMA should provide the individual physician all possible assistance in carrying out his responsibilities in his practice and in his community. We currently are doing a great deal for the individual doctor indirectly through his county society, and directly through CMA: Communications, physician placement, group insurance, the Keogh retirement plan, continuing education, and representation with government and many private sector associations. We could be doing much more. Today's physician faces many problems which did not exist 10 years ago. New problems have arisen from complex new laws and regulations; new drugs; new concepts in business, communications, and health facility planning; new insurance programs; new responsibilities for hospital medical staffs, extended care facilities and the organization of hospital-based practice groups.

Do we know what information and assistance our doctors need and want in tackling these new problems? **One of our goals should be to find out what physicians need in these areas and to do our best to fulfill these needs.**

Continued Assurance of Highest Quality Health Care

In pursuing these objectives and carrying out the many programs of CMA, we must not lose sight of the fact that the primary function of the profession and of related health personnel is to provide to all the people in the State of California, the highest possible quality of health care, delivered in such a manner as to afford satisfaction to the public and the health professions, while conserving the time and resources available to each.

Our Association must continue its studies to identify conditions and situations which detract from maximum performance in the rendering of health care services—and to make suggestions for improvement. In cooperation with Blue Shield, in-

surance carriers, foundations and county societies we must continue our activities to assure ourselves and the public that the profession is indeed providing high quality of care, at a reasonable cost and with a minimum of abuse. It would appear that we are doing a commendable job. **Our goal should be that of continued and improved performance, which will justify our own pride in our distinguished profession as well as high public esteem for doctors of medicine.**

SUMMARY OF 1967-1968 CMA GOALS

1. To work toward fulfillment of our primary objective of improving the practice of medicine and the health of the public within the unique and changing environment of the State of California, utilizing as intelligently and as effectively as possible all of our available resources.

2. To evaluate all CMA programs and activities to determine their effectiveness in achieving significant benefit to the public and the profession.

3. To expand and strengthen CMA's governmental relations activities.

4. To modernize our methods of fact-finding so that we may better utilize the resources available to CMA and component societies.

5. To launch a concerted effort to bring all segments of the medical profession into CMA membership.

6. To increase active physician participation in the affairs of organized medicine, providing adequate financial compensation when it appears justified.

7. To expand necessary and desirable services for the individual physician to help him practice more efficiently, to reduce frustrating annoyances and to increase his satisfactions from practicing his profession.

8. To continue studies and promote cooperative programs to assure a high level of performance in providing quality medical care to all of the people of California.

Controls on Outlays For Medi-Cal Care

COMPROMISE AMENDMENTS offered by the Committee on Conference on A.B. 583 were adopted by both houses of the legislature 4 May 1967 and sent to Governor Reagan for his signature.

The conference amendments removed those persons who are not Group I or Group II (categorically aided or certified medically indigent) recipients from the $18.25 per month formula for computing the maximum amount available for care of California Medical Assistance Program recipients.

The compromise amendments also give the Health and Welfare administrator the authority not only to limit the scope of services to be provided, but also to "limit the rates of payment for such services."

The compromise puts two controls on county expenditures for noncategorical aid recipients. One control requires counties, after 30 June 1967 to have prior authorization from the state for any increase in cost because of new standards for medical aid and care, scope and level of services, or obligations for medical care.

The other limits the state's obligations to pay counties for authorized increased costs to $44 million in the 1967-68 fiscal year. The amount of this maximum obligation would be fixed each subsequent year by the legislature in the budget.